State of Rhode Island & Providence Plantations
DEPARTMENT OF ADMINISTRATION
Office of Employee Benefits
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Summary of Your Retiree Value Plan Medical Benefits

March 1, 2014

Dear Retiree:

This letter and attached chart provide a summary of your State of Rhode Island retiree medical benefits. Our health plan gives you the freedom to see any physician or other health care professional from the UnitedHealthcare Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that you may be required to pay higher co-payments for care received from a non-network physician, facility or other health care professional. In addition, if you choose to seek care outside the Network, you will also be responsible for payment of the difference between the provider's billed charges and the expenses eligible for reimbursement. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*. You may also call UnitedHealthcare directly at (866)202-0434 or check online at www.myuhc.com to determine if a physician or facility is in the Network.

A detailed Summary Plan Description (SPD) is available on-line at www.employeebenefits.ri.gov. Please refer to the SPD for a complete up-to-date listing of services, limitations, exclusions, and a description of all the terms and conditions of coverage. Printed copies are available upon request. If you have questions about whether or not a procedure is a covered benefit, please call UnitedHealthcare at (866) 202-0434.

Sincerely,

Office of Employee Benefits

State of Rhode Island Benefits Summary:

Retiree Value Plan, Updated 3/1/14.

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
Annual Deductible	$2,000 per Covered Person, not to exceed $4,000 for all Covered Persons. The Out-of-Pocket maximum does not include the Annual Deductible.	$5,000 per Covered Person, not to exceed $10,000 for all Covered Persons. The Out-of-Pocket maximum does not include the Annual Deductible.
Out of Pocket Maximum	$4,000 per Covered Person, not to exceed $8,000 for all Covered Persons.	$10,000 per Covered Person, not to exceed $20,000 for all Covered Persons
Maximum Policy Benefit	No Maximum Policy Benefit	No Maximum Policy Benefit
1. Ambulance Services – Emergency		
Ground Transportation	30% of Eligible Expenses after deductible	Same as Network Benefit
Air/Water Transportation	30% of Eligible Expenses after deductible	Same as Network Benefit
2. Cardiac Rehabilitation 36 visits	$35 per visit	50% of Eligible Expenses after deductible
3. Chiropractic Treatment Maximum 24 visits per calendar year.	$35 per visit	50% of Eligible Expenses after deductible
4. Dental Services– Accident only	*30% of Eligible Expenses after deductible *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
5. Diabetes Education	$35 per visit	*50% of Eligible Expenses after deductible

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
6. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per calendar year. This benefit category contains services/devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	*30% of Eligible Expenses after deductible *Prior notification is required when the cost is more than $1,000.	*50% of Eligible Expenses after deductible *Prior notification is required when the cost is more than $1,000.
7. Emergency Health Services Covered anywhere in the world	$150 per visit **Notification is recommended if results in an Inpatient Stay.	Same as Network Benefit **Notification is recommended if results in an Inpatient Stay.
8. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider	$35 per visit	50% of Eligible Expenses after deductible Eye Examinations for refractive errors are not covered.
9. Hearing Aids Must be ordered by physician. Benefits are $3,000 per year and are limited to a single purchase (including repair/replacement) every two years.	0% of Eligible Expenses	50% of Eligible Expenses after deductible
10. Home Health Care Network and Non-Network Benefits are limited to 6 home or office Physician's visits per month, 3 nursing visits per week and 20 hours of home health aide visits per week	*30% of Eligible Expenses after deductible	*50% of Eligible Expenses after deductible
11. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy	*30% of Eligible Expenses after deductible	*50% of Eligible Expenses after deductible
12. Hospital – Inpatient Stay	**30% of Eligible Expenses after deductible	**50% of Eligible Expenses after deductible

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
13. Infertility Services	20% of Eligible Expenses after deductible	20% of Eligible Expenses after deductible
14. Injections Received in a Physician's Office	$35 per visit	50% of Eligible Expenses after deductible
15. Maternity Services	Same as 12, 17, 19 and 20 No copayment applies to Physician office visits for prenatal care after the first visit in which a $35 copayment applies. Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	50% of Eligible Expenses after deductible
16. **Mental Health and Substance Use Disorder Services – Outpatient** **Inpatient and Intermediate** Mental Health *Substance Abuse Rehabilitatio*n *Substance Abuse Detoxification*	$35 per visit **30% of Eligible Expenses after deductible	50% of Eligible Expenses after deductible **50% of Eligible Expenses after deductible
Residential Treatment – limited to In-Network Providers only		Residential Treatment is not available Out-of-Network
17. Outpatient Services		
Outpatient Surgery	30% of Eligible Expenses after deductible	50% of Eligible Expenses after deductible
Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine	30% of Eligible Expenses after deductible	50% of Eligible Expenses after deductible
Outpatient Diagnostic Services	For lab and radiology/X-ray: No Copayment	50% of Eligible Expenses after deductible
	For mammography testing: No Copayment	50% of Eligible Expenses after deductible

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
18. Physical/Occupational Therapy Network and Non-Network benefits are limited to 20 visits of physical therapy; 20 visits of occupational therapy	$35 per visit	50% of Eligible Expenses after deductible
19. Physician's Office Services	$35 per visit	50% of Eligible Expenses after deductible
20. Preventive Care Services Covered Health Services include but are not limited to: Primary Physician Office Visit Specialist Office Visit Lab, X-ray or Other Preventive Tests	 $0 $0 $0	50% of Eligible Expenses after deductible. No benefits for preventive care after age 19. Deductible does not apply to preventive care for Dependent children 19 or younger.
21. Professional Fees for Surgical and Medical Services	30% of Eligible Expenses after deductible	50% of Eligible Expenses after deductible
22. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year.	30% of Eligible Expenses after deductible	50% of Eligible Expenses after deductible
23. Scalp Hair Prosthesis Network and Non-Network Benefits for a scalp hair prosthesis are limited to $350 per calendar year.	30% of Eligible Expenses after deductible See Maximum Plan Benefit at left	50% of Eligible Expenses after deductible See Maximum Plan Benefit at left
24. Skilled Care in a Nursing Facility Network and Non-Network Benefits are limited to 60 days per calendar year.	*30% of Eligible Expenses after deductible	*50% of Eligible Expenses after deductible
25. Speech Therapy Outpatient Network and Non-Network are limited to 20 visits per calendar year	$35 per visit	50% of Eligible Expenses after deductible
26. Transplantation Services Must be performed at a Center of Excellence	*30% of Eligible Expenses after deductible	*50% of Eligible Expenses after deductible. Benefits are limited to $30,000 per transplant.

Covered Health Service	*Within the UHC Network you pay:*	*Outside of the UHC Network you pay:*
27. Tobacco Cessation Treatment – Outpatient Visits Network and Non-Network Benefits are limited to eight, thirty (30) minute counseling sessions each calendar year.	0% of Eligible Expenses	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Certificate of Coverage.
28. Urgent Care Center Services	$50 per visit	50% of Eligible Expenses after deductible
Pharmacy Coverage (Provided by CVS Caremark) **Quantity Limit per co-payment:** ▪ Up to a 31-day supply	$10 Tier 1 $30 Tier 2 $50 Tier 3	$10 Tier 1 $30 Tier 2 $50 Tier 3
Mail Order **Quantity Limit per co-payment:** ▪ Up to a 90-day supply	$25 Tier 1 $75 Tier 2 $125 Tier 3	Not Covered

*Prior notification is required for certain services.

**Prior notification is recommended for this service. If you do not notify us and the services are determined to be not medically necessary or the setting where services were received is determined to be inappropriate, this plan will not cover these services.

Non-Network Charges: If you choose to seek care outside the Network, you will also be responsible for payment of the difference between the provider's billed charges and the expenses eligible for reimbursement.

Dependent Age: Children are eligible for coverage until the end of the month that the child turns age 26, provided the child does not have access to employer-sponsored medical insurance through his/her employer.

This Summary of Benefits is intended only to highlight your benefits and should not be relied upon to fully determine coverage. More complete descriptions of Benefits and the terms under which they are provided, including related exclusions, are contained in the Summary Plan Description available online at www.ersri.org. This plan may not cover all your health care expenses. Please refer to the Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Summary Plan Description, the Summary Plan Description prevails. Terms that are capitalized in the Benefits Summary are defined in the Summary Plan Description.